STUDIES IN FORENSIC PSYCHIATRY

CHAPTER I

PSYCHOGENESIS IN THE PSYCHOSES OF PRISONERS

THAT mental disorder may be due to causes purely psychic in nature is acknowledged by everyone. The older psychiatrists laid much stress on this point, a revival of which may be seen in the present-day widespread psychoanalytic movement. The reaction to the all too-embracing materialistic tendencies which have dominated psychiatric thought in recent decades was bound to come. It was especially the clinician who gave the impetus to this movement, because in pursuing the materialistic bent he found himself totally helpless as a therapeutist in the great majority of mental cases, and was therefore eventually forced to seek more promising paths.

Bleuler's attitude towards this question, because of the prominent position he occupies in the world of psychiatry, is interesting.

"Bleuler, who succeeded Forel as Professor of Psychiatry and Medical Director of the Cantonal Insane Asylum (Burghölzi) at Zurich, having become convinced

that no solution could be arrived at along this anatomical path for the many riddles offered by the disturbed mental life, had for years chosen the psychological path. He was led to take this course because he knew that of the chronic inmates of the asylum, only about one-fifth showed anatomical changes of the central nervous system sufficient to explain the mental deviations exhibited." [1]

The results already achieved by this change of attitude in psychiatry are sufficient justification for its existence.

One became especially convinced of the potency of mental factors in the production of mental disease from the observation and study of the psychoses of criminals. Here the conflicts which lead an individual to seek in mental disorder a satisfactory compromise are so concrete as to leave no doubt concerning cause and effect.

Kraepelin [2] asserts that mental disorders occur ten times as frequently in prison as in freedom. The criminal, who in most instances is already burdened with a more or less strong predisposition to mental disorder, upon being placed in prison finds himself at once in a most favorable environment for a mental breakdown. It is true, imprisonment acts more deleteriously upon the psyche of the criminal by passion, the accidental criminal, but even the recidivist who would be expected to feel less keenly the painful loss of freedom, falls a prey to the deleterious effects of prison life. The unfavorable hygienic surroundings which are found in most prisons, the scarcity of air and exercise, readily prepare the way for a breakdown, even in an habitual criminal. Above all, however, it is the emotional shock and depression which invariably accompany the

painful loss of freedom, the loneliness and seclusion, which force the prisoner to a raking occupation with his own mind, to a persistent introspection, making him feel so much more keenly the anxiety and apprehension for the future, the remorse for his deed, that play an important rôle in the production of mental disorders. This is especially true when it concerns an accidental criminal, one who still possesses a high degree of self-respect and honor. Imprisonment furnishes us with a great variety of mental disorders, the origin of which can be traced in a more or less direct manner to the emotional shock and influence upon the psyche which it brings about.

The psychogenetic origin of the psychoses of criminals can be established far more clearly in prisoners awaiting trial. Here the deleterious effect of confinement upon the physical health can be ruled out almost entirely, and the etiologic factor must be sought for exclusively in the emotional shock which the commission of the crime and its attending consequences provoke. The strong effect upon the psyche produced by the detection and confinement, the raking hearings and cross-examinations, and the uncertainty and apprehension of the outcome of it all are the factors that are at play here.

Reich,[3] in 1871, was the first one to call attention to the mental disorders of prisoners awaiting trial. He could observe the development of mental symptoms even during the first hours of confinement, and the relation between the psychosis and the emotional shock of the situation at hand could not be doubted. He describes this acute mental disturbance as follows: — "Already in the first hours or days after imprisonment, or soon after a severe emotional shock, a sort of

psychic tension sets in. The prisoner becomes silent, chary of words, lost in brooding. He observes little that goes on about him and remains motionless in one spot. His face takes on an astonished expression, the gaze is vacant and indefinite. If he makes any movements at all they are hesitating, uncertain, as those of a drunken man. Vertigo and aura-like sensations appear; severe anxiety overpowers the patient, which with the entire force of a powerful affect crowds out all other concepts and sensations and dominates the entire personality. Consciousness becomes more and more clouded, soon illusions, hallucinations, and delusions appear, and the prisoner becomes especially taken up with ideas of unknown evil powers, of demons and spirits, and of being persecuted and possessed by the devil. Simultaneously they complain about all sorts of bodily sensations. In isolated cases one may observe convulsive twitchings of the voluntary and involuntary musculature. Finally severe motor excitements set in. The patient becomes noisy, screams, runs aimlessly about, destroys and ruins everything that comes his way. With this the disease has reached its height. At this stage consciousness is entirely in abeyance and the disorder is followed by complete amnesia." Reich supposes that this acute prison psychosis may be included in that large group of abnormal psychic processes, developing from affect and affect-like situations.

Reich's important work remained the only one on the subject until 1888, when Moeli again called attention to it. Moeli [4] spoke of patients in whom an apparent total blocking of all thought processes took place. They would exhibit complete ignorance of the most commonplace facts, would forget such well-known things as their own name, place of birth, or age; were

unable to recognize the denominations of coins, etc. He noted, however, that although the answers these patients gave were false, they had a certain relation to the question. For instance, coins of a lower denomination would be mistaken for higher ones, postage stamps were called paper, etc. They also showed a marked tendency to elaborate all sorts of false reminiscences about their past life. Along with this failure of the simplest thought and memory activity, these individuals were otherwise well-ordered and behaved.

The reader will at once recognize in the above description the well-known Ganser symptom-complex, the several variations of which have been so frequently discussed of late years. Ganser[5] further showed that these cases frequently evidenced vivid auditory and visual hallucinations. At the same time there existed a more or less distinct clouding of consciousness, with the simultaneous presence of hysterical stigmata, especially total analgesia. After a short time recovery took place, the patients suddenly awoke as if from a dream and evidenced a more or less complete amnesia of the events which had transpired.

Numerous discussions concerning this disease-picture have appeared of late years in literature. The Ganser syndrome, or twilight state, has been enlarged upon, and several variations of this condition have been isolated. The chief contention, however, of the various authors on this subject seems to be whether this symptom-complex should be considered as hysterical or whether it should be placed among the large group of degenerative states. Both views are ably defended by prominent psychiatrists. I have recently observed the Ganser syndrome in an undoubted case of toxic-exhaustion psychosis.

Raecke [6] designated this disease-picture described by Moeli and Ganser as an hysterical twilight state in psychopathic individuals. These conditions were developed in them as the result of emotional excitement in imprisonment. The constant hearings, the confusing cross-questioning, the fear of punishment, finally the injurious effect of solitary confinement, shock and weaken the slight mental tension of the prisoner to a marked extent. As a result of this, we have on the one hand a condition of apathy, of inability to concentrate the mind, of incapacity to think and of a sort of feeling of being wholly at sea, accompanied by vertigo and other nervous manifestations, while on the other hand the physical despair, the obstinacy of the prisoner, now increase to pathological maniacal attacks, now again are changed to stubbornness, mutism, with refusal of food. At the same time the more or less constant wish to be considered sick, and in consequence to be freed from imprisonment (and in this we see perhaps the hysterical component), may influence deleteriously and in a peculiarly modifying way the disease-picture. The various questions put to the patient by the examiner may act as so many suggestions. Raecke further calls attention to the manifold similarities which these conditions may show with catatonic processes. In these hysterical twilight states, quite aside from mutism, negativism, and catalepsy, peculiar mannerisms were noted, a sort of affected, childish way of speaking, motor stereotypies, swaying of the head, running in a circle, queer actions, and sudden expressions of senseless word combinations. In a later work Raecke [7] describes a symptom-complex, which he designated as "hysterical stupor in prisoners", and in which the catatonic symptoms exist in a still more pronounced

manner. The severe forms of this disorder, which may extend over weeks and months, are liable to be confused with progressive deteriorating processes, especially so because those symptoms which were wont to be considered by many as positively unfavorable prognostically, may be found here in very deceptive imitations. Thus the affected, silly behavior, impulsive actions, temporary verbigeration, senseless word salad, grimacing, stereotypy, attitudinizing, etc., which these patients exhibit, may easily be mistaken for the typical catatonic picture of dementia præcox. According to Raecke's view the hysterical stupor is closely related to the Ganser twilight syndrome. Stuporous conditions may introduce the latter, and, vice versa, Ganser complexes may creep into the stupor. Raecke's stupor, like Ganser's twilight syndrome, frequently develops in criminals immediately after arrest or as a result of great physical or psychic exertion. Sometimes the stupor is preceded by convulsions, at other times by a prodromal stage of general nervousness. In still other cases, unpleasant delusions and elementary hallucinations precede the stupor, which may follow immediately after this prodromal state or may be again preceded by a short attack of mania with clouded consciousness. In contrast to the genuine catatonia, Raecke's stupor as well as Ganser's twilight state, are characterized by *a high grade of impressionability to things in the environment, which may at any time suddenly cause a complete transition from an apparently deep stupor to normal manner and behavior.* Headaches, vertigo, and various hysterical stigmata are common to both the hysterical stupor and the Ganser twilight state. At times recovery takes place suddenly, but as a rule it is gradual and remittent in character. The duration of the

disorder differs. It may last for hours or months, and there generally remains a more or less pronounced amnesia for the entire period of stupor.

Kutner,[8] in a work on the catatonic states in degenerates, describes this condition at length. Although recognizing a good many hysterical features in these patients, he prefers to place these catatonic conditions under the general group of the psychoses of degeneracy. He does not add anything worthy of note to what Raecke had to say concerning this mental disorder, but the differentiating points which he advances between it and the genuine catatonia are of interest and should be mentioned here. Among these he mentions, first, the development of the disorder upon a grave degenerative basis; second, the sudden development of the psychosis as the immediate result of a situation strongly affective in nature, such as a threatening or beginning prolonged imprisonment; third, the more or less sudden disappearance of the entire symptom-complex upon a change of environment; and lastly, the lack of secondary dementia. This absence of dementia cannot be explained by mere assertions that these cases have perhaps not been followed out long enough. Bonhoeffer kept account of some of these cases for as long as ten years, and in none of them could he observe any sign of a deteriorating process.

It may, perhaps, be of interest to finally mention here Raecke's fantastic form of degenerative psychosis, which is nothing more nor less than another attempt at describing the original Ganser twilight state in a modified form.

It will be seen from the preceding that the disease-pictures described by Reich, Moeli, Kutner, Ganser, Rish, and others, are so closely related that any attempt

at separation must of necessity be more or less of an artificiality. The question whether this condition, because of certain isolated hysterical components, deserves to be considered as hysterical in nature, is by no means solved. The mere presence of physical, so-called hysterical, stigmata, is not sufficient to call a disorder hysterical. Bonhoeffer, who, in opposition to such authors as Willmanns, Birnbaum, Siefert, and others, insists that this so-called prison-psychotic-complex in its narrower sense is of hysterical nature, does so because he claims to be able to see in these patients the dominance of a wish factor, namely, the wish to be considered insane, and consequently to be transferred to an institution for the insane.

He explains the recovery of these patients upon being transferred to such an institution on the basis of the fulfillment of this wish. My experience has been that it is very difficult in most instances to differentiate these acute psychogenetic states from certain hysterical conditions. Some of them show a good many hysterical symptoms, while in others such symptoms are absolutely wanting. One of the cases herein reported illustrates this point especially well. This patient was admitted to our hospital on two occasions, the first time while awaiting trial on a charge of murder, and the second time soon after conviction and sentence to life imprisonment. His first attack showed very little, if anything, of a hysterical nature, while his second attack had so many features of hysteria that it could hardly be considered anything but a psychosis of an hysterical nature.

Case I. — E. E., Negro, aged 32 years. One sister insane, a brother is said to be subject to convulsions. Patient's

birth and childhood normal; attended school for three or four years, where he made normal progress. He entered upon the life of a common laborer when quite young, and always managed to earn a substantial livelihood for himself and family. With the exception of typhoid fever at six or seven years, he was never ill before. He used alcoholics in moderation, and denies venereal history. Criminal history is uncertain; according to his statements he was arrested but once before, for fighting. It appears that he was working as usual until August 19th, when he was arrested on a charge of assault and robbery. The patient has a hazy recollection of this; he cannot say how long ago it was, but thinks it was sometime in August; he was arrested at night; cannot state at just what time, but is certain that it was after sunset; does not know who arrested him; says there were several of them; does not know whether they were policemen or detectives. The police records show that he was arrested on the night of August 19th, after a desperate fight. The following day he suddenly became insane in his cell at the fourth precinct station house. He became very excited; commenced to shout that he had been shot in the abdomen by an enemy. When offered food he threw it at the policeman through the bars of his cell door, and then began beating his head against the walls of his cell. He was transferred to the observation ward at the Washington Asylum Hospital. The records of that institution show the following: On admission he was yelling, cursing, and very much excited; completely disoriented; repeated the same sentence over and over again in a singing fashion. He talked to the Lord, and answered imaginary questions; had auditory and visual hallucinations, and various delusional ideas; thought someone was talking to him constantly; that he was being shot at every few minutes, and yelled with anguish at every supposed shot. He cried and sang alternately.

Owing to his marked excitement he had to be kept in constant restraint.

On admission to the Government Hospital for the Insane, on August 23d, three days after the onset of the disorder, he was in a semi-stupor; no replies could be gotten to questions, and his attention to the extent of looking at the examiner could be engaged only after vigorous shaking. General hypalgesia was present; he responded but very feebly to pin pricks. He was absolutely passive to the admission routine, and offered no resistance whatever to what was being done to him. His body did not show any resistance to passive movement, on the contrary, it was rather limp. He was lying in bed staring in a fixed manner straight ahead of him and would emit an occasional grunt, and a few unintelligible words. He refused nourishment, was untidy in habits, and appeared to be wholly oblivious to his environment. Respiratory and cardiac action somewhat accelerated, pulse rapid and feeble.

August 25th: — Continues in the same stuporous state; absolutely oblivious to his surroundings; refuses food; untidy in habits. Aside from an unintelligible word or two, has not spoken any since admission. There are several beginning pustules on his back.

August 28th: — Some improvement noted; asks for water spontaneously; when spoken to says his back aches, and that they are pouring water on him. "I read the book, I went to church." Unable to feed himself or dress without assistance; totally disoriented.

August 30th: — Came out in the hall today, and spent the time sitting quietly on a settee; does not take any interest in his surroundings; has not spoken any spontaneously. Answers are given in a brief and retarded manner, preferably in monosyllables, and not to the point. On being questioned concerning orientation, says: "My

back, church, the book", "they are burning me up." Appearance indicates marked confusion.

September 3d: — The patient suddenly became clear mentally this morning; seems to have completely recovered from his stupor; attends to his wants, and answers questions in a clear, coherent manner. Approached the physician this morning and asked for a laxative; says that he remembers nothing that transpired during the period since his arrest, and a day or two ago, when he began to see things more clearly; complains of pain in back; does not know where he is, and thinks he came here yesterday.

"What is your name?"

"E. E."

"Age?"

"I will be 33 the 16th of this coming April."

"When were you born?"

"In 1879."

"What is your occupation?"

"I am supposed to be a huckster."

"Where were you born?"

"At Columbus, South Carolina."

"What day is this?"

"Sunday." (correct)

"Date, month and year?"

"It's the 9th month, 1911, I don't know the date; I have not seen an almanac."

"What is the time?"

"I don't know, sir; I think it is pretty near one o'clock." (correct)

"Where did you come from?"

"I don't know where I came from; they hit me over the head."

"When did you come here?"

"I don't know; I look out of that building that looks

like the House of Rep." (After studying the surrounding country a while, says: "Let's see, this must be Anacostia, ain't it; I never was out here before." (correct)

"How long did it take you to get here?"

"I don't know, sir."

"Name of this place?"

"You've got me now."

"Where is it located?"

"It seems to be in Anacostia, the way I can figure it out." (correct)

"What sort of a place is it?"

"Well, to my judgment, it looks as though it's all right."

"Who are these people about you?"

"I don't know, sir."

"Is there anything wrong with them?"

"Well, I don't know, I am afraid to say; I don't know the nature of anybody but myself."

"Why do you suppose you are being asked these questions?"

"Well, I think it is to sound my knowledge."

"Why were you sent here?"

"I don't know, sir."

"How do you feel?"

"I feel all right, with the exception of my back."

"Are you happy or sad?"

"Well, I am neither one."

"Are you worried about anything?"

"No, sir."

"Did anything strange happen to you for which you can't give yourself an account?"

"I can't understand what happened to me, or why I am here."

"Do you hear voices talking to you?"

"No, sir."

"Do you see any strange things?"

"No, sir, I don't see anything strange, only my surroundings."

"Do you ever have fits or convulsions?"

"No, sir."

"Did you ever try to commit suicide?"

"No, sir, and ain't never going to try it."

"Is anybody trying to harm you in any way?"

"Yes, I really believed somebody tried to do something to me."

The foregoing questions were answered without any hesitation and in a prompt manner.

September 6th: — Today, patient gave in a coherent and relevant manner his past history. He talked freely, and all evidence of suspiciousness or evasiveness was absent. Upon examination he was found to be perfectly oriented in all spheres; free from delusions and hallucinations, and possessing quite a degree of insight into his recent mental disorder. While reluctant to admit that he had been insane, he fully realized that something was wrong with him. He showed a normal emotional reaction to the situation at hand; felt satisfied with his surroundings, and was very much concerned and anxious about his release. Special intelligence tests failed to reveal any intellectual defect. He was found, however, to be a rather ignorant negro. Memory and attention were unimpaired. Apperception good; physical examination showed him to be a well-developed man of medium size, height five feet, three inches, weight 150 pounds. Aside from several pustules on the back, he showed no physical disorders. Neurological examination, negative.

September 14th: — Patient was today discharged by a jury, as not insane. He presented a normal appearance upon leaving the Hospital. Insight was good, and there

existed a total amnesia for the period between August 19th, when he was arrested, and September 3d, when he recovered from his stupor.

This case illustrates in an excellent manner the development of a mental disorder as an immediate consequence of a situation strongly affective in nature, — in this instance, threatened imprisonment for a grave offense.

The emotional shock of the arrest called forth in this, to all appearance, previously normal individual, a marked excitement accompanied by hallucinations and fleeting delusional formations. This excitement, which required the application of constant restraint, was followed by a stuporous state and total clouding of consciousness. Upon being removed to a hospital, and surrounded by a new environment, patient gave evidence, after a sojourn of only a few days, of the salutary effect of such procedure. On September 3d, ten days after admission, the stupor disappears, and the only residue of the one-time psychosis is a complete amnesia for the entire period. The amnesia and the hypalgesia, which the patient manifested on admission, are the two symptoms which may perhaps be considered as more or less hysterical in nature. Aside from this, it is difficult to see wherein the psychosis resembles an hysterical disorder. Another point which should be mentioned here in passing, and which will be dilated upon later, is the medico-legal importance of this class of cases. This patient was wanted for assault and robbery in an adjoining State. Upon his admission to this institution an inquiry was received from the U. S. Attorney for the District of Columbia as to the probable duration and course of this man's disorder, as they

had in possession extradition papers from the authorities of the State in which the crime was committed. It was only by recognizing the nature of this disorder that we were able to furnish the authorities with intelligent information concerning the prognosis of the case, and which the course of the disease corroborated in every detail. By recognizing the fact that these disorders are consequences of the criminal act, the possibility of considering the man insane at the time of the commission of the act is obviated in a large measure.

CASE II. — R. S. C., a white male, age 48 years, who is now serving a life sentence for murder. One brother and one sister died of tuberculosis. Another sister and two maternal aunts were insane. Father alcoholic. Patient has always been regarded as rather sickly. Had the usual diseases of childhood and has been subject all his lifetime to frequent headaches. His school career was very irregular in character and he never advanced beyond the elementary subjects. Socially, he belonged to a very ordinary stock of frontiersmen and his chief occupation consisted of farming and certain minor speculations. He apparently led an honest and more or less industrious life. Married in 1886, and his conjugal career is uneventful. In March, 1901, he moved to Addington, Indian Territory. This was a newly-established frontier town and he had bought, sometime previously, several lots there, intending to establish himself in the lumber business. Soon after this he got into some financial difficulty with a town-site boomer, and finally, in a fit of passion, shot and killed the latter and wounded a relative of his own. He was admitted to the Government Hospital for the Insane, December 13, 1901, from the Indian Territory. From the medical certificate which accom-

panied him on admission it appeared that soon after the commission of the crime the patient began to show evidence of insanity by incoherent talk, false ideas, nervousness, and outbursts of vicious excitement. Later, this was followed by mutism, refusal to eat, and stupor. On admission to this hospital he was in a deep stupor, absolutely oblivious to everything about him. Eyes were wide open and staring, pupils dilated, voluntary movements markedly in abeyance. He was mute except for an occasional incoherent mumbling to himself. He evidenced no initiative in feeding himself, but swallowed food when it was placed in his mouth. Habits were very untidy; involuntary evacuation of bladder and bowels were present. His mental content could not be determined at the time, as his replies were indistinct and monosyllabic, and were obtained only after much effort. He appeared to comprehend what was wanted of him, although this was not absolutely certain. His perception was very dull, ideation slow and laborious. His attention could be gained only after considerable difficulty, and he had to be aroused first from a more or less profound stupor. Spontaneous speech was almost wholly absent, but occasionally he would utter a word or two about his wife and children. No delusions or hallucinations could be elicited. Physical examination showed him to be quite thin and emaciated. Gait slow and unsteady. Voluntary movements retarded. Knees trembled and knocked against each other. No paralyses or pareses noted. Marked general tremors were occasionally seen. Musculature well developed but flaccid. All deep reflexes diminished. Cremasteric absent. Other superficial reflexes were noted to be normal. Organic reflexes abolished. Involuntary urination and defecation. There was a systolic murmur present and a slight impairment of the upper lobe of the right lung. Breath very offensive. He remained in this stuporous condition,

leading a more or less passive existence, for about a month after admission. For two months following this he was quite agitated, and his outward reactions indicated that he was quite depressed. On April 25th, about four and a half months after admission, when asked how long he had been in the Hospital, he replied three days. From that time on he began to improve. Consciousness became clearer. In June, he talked and acted quite rationally. He had a total amnesia of what had transpired during his stuporous and agitated states and a retrograde amnesia for several days prior to, and including the commission of the murder. He continued clear mentally and in a more or less normal state until the latter part of November, 1902, when he again went into a stupor. From this time until the later part of April, 1903, he had alternating periods of stupor and lucidity, with amnesia for the stuporous states. On June 21, 1903, he was discharged as recovered and returned to the Indian Territory to undergo trial for his offense. Unfortunately, no mention is made in the hospital records of any possible relation between his periodic stuporous states and any environmental condition which may have provoked these; nor does there appear in the hospital records any mention of the degree of insight, if any, the patient possessed at the time of his release from the institution.

He remained in jail at Ardmore, I. T., until April 8, 1904, when he was tried and found guilty of murder in the first degree. He was then returned to jail and after about a year's sojourn there was sentenced to life imprisonment and transferred to the United States Penitentiary at Leavenworth. He was readmitted to the Government Hospital for the Insane on March 25, 1906, from the United States Penitentiary at Leavenworth. No medical certificate accompanied him on admission and it is therefore impossible to set, even an approximate date, for the onset of his present

mental disorder; but inasmuch as he had not been in prison even a year before his transfer to our hospital, and as it usually takes several months to carry out the required legal proceedings, his mental disorder must have set in quite soon after his confinement in the penitentiary.

He was again in a stuporous condition on his readmission to our hospital, and absolutely oblivious to his surroundings. For about twenty-four hours he was wholly inaccessible, would not reply when spoken to, and had to be aroused from a sort of lethargic state before his attention could be gained at all. On the following day consciousness cleared up to some extent and he recognized some of the attendants whom he had known on his previous admission. He remained, however, more or less confused for several days, after which his mental horizon became clear, and simultaneously with this, delusions of suspicion and persecution became evident. He did not know how long he had been in this confused state and had a complete amnesia for the entire period. Stated that he had been poisoned and that attempts to kill him had been made at the Penitentiary. He knew he had been doped any number of times. Aside from this paranoid complex he had a complete left-sided functional hemiplegia with all the concomitant signs. Left visual field considerably contracted. From May, 1906, to February, 1907, he passed through a number of stuporous periods, during which he was confined to bed from a few days to a week at a time. At these times he would lie with a vacant and staring expression, and questioning would often fail to elicit any reply. At times he would partake only of liquid nourishment, then again would have to be spoon-fed. During his lucid intervals he would be up and about and more or less cheerful. Occasionally played games with his fellow patients. He continued to be very suspicious; frequently spoke of being doped and poisoned. Refused to

take medicine, and at times refused to take nourishment because he believed it to be doped. A stenogram of February 10, 1907, shows him to have acquired some grandiose ideas and to be still disoriented to a large extent. Some of his replies were absolutely unreliable. For instance, when asked how long he had been here he replied: "If I came on March 25th, I have been here for three hundred and sixty-five thousand days. It is reasonable but you wouldn't understand it. When a man is answering for something he should not answer for, every day amounts to a thousand years with the Lord." He stated that he knew that attempts were being constantly made to affect him with chemical substances; these were placed in his food and rubbed on the walls of his room, making him dizzy and giving him a sort of peculiar feeling, etc. He could hear of things occurring in distant places and even in foreign countries just as though he were there. He could tell what was going to happen; had no trouble at all to look into the future. He attributed this ability to some superhuman power, but which was natural to him. This power was bestowed upon him by the superhuman power itself. In prison every possible means to kill him were used but without success. They even tried to chloroform him for a day and a night, but could not kill him.

May, 1907: — Still delusional, hypochondriacal; paralysis very much improved. Complains at times of quiverings in the right extremities and a numbness of the left side.

August, 1907: — Has been again in a stuporous state for four days. Still entertains paranoid ideas, hypochondriacal. This was followed by a lucid period which lasted until November 25th, when he again went into a profound stupor and became totally oblivious to everything about him.

April, 1909: — Very much disturbed for about a week. Complained that the physicians and attendants were tor-

turing him in order to drive him insane. Called them brutes and threatened to starve himself to death.

December, 1909: — Neurological Examination — Hemiplegia almost entirely disappeared, but numerous physical stigmata still persist. Has been uninterruptedly clear mentally since his last stuporous state, in November, 1908.

January, 1911: — Clear mentally. Answers questions coherently and readily. Attention easily gained and held without difficulty. Memory, for both recent and remote events, fair, with complete amnestic gaps for the stuporous periods. He shows the characteristic hysterical make-up. He is morbidly suggestible and suspicious. He is markedly egotistical; becomes easily irritated at the least provocation. Is extremely hypochondriacal and shows a marked tendency to exaggeration of actual ills. Constantly laments his fate of being compelled to stay in a place of this sort, which is a thousand times worse than a prison. Is certain that his trial was crooked and irregular and that he had not been given a fair chance. His sentence is inhuman and unjust, as he was not responsible for the crime he committed; he remembers nothing of the occurrence and consequently must have been insane at the time. He is inclined to a great deal of fantastical day-dreaming, writes poetry and religious dissertations. He is constantly bewailing his unfortunate lot in letters to people of high station, imploring their compassion on the poor, down-trodden martyr. Is clear mentally throughout and no definite delusions nor hallucinations can be elicited. His morbid suspiciousness, however, leads him to interpret various occurrences in his environment in a more or less delusional manner.

August, 1911: — No change from the above note except that the physical stigmata have almost completely disappeared. Patient has an adequate amount of insight into

his stuporous state, but does not realize that his entire make-up is more or less pathological in character.

The patient had finally sufficiently recovered to be able to be returned to the Penitentiary, and as he was very desirous of the change, he was, accordingly, discharged from further treatment, March 25th, 1912, to be returned to the United States Penitentiary, Leavenworth, Kansas. At this date, November, 1915, I am informed that the patient gets along very well at the Penitentiary, working in the hospital of that institution.

We are dealing here with an individual who, to start with, comes from a badly tainted family. He leads an honest, more or less industrious life, until one day, in a fit of passion, he shoots and kills a man with whom he has some financial differences. Being uncorrupted and of a non-criminal make-up, the enormity of his crime suddenly dawns upon him with its full force. He is unable to withstand the emotional shock which the realization of his deed provokes, breaks down under the stress, and develops a mental disorder. He is removed to a hospital and under the salutary influence of new environment gradually recovers his normal mental health. Simultaneously with this he begins to nourish the hope that he may escape punishment for his deed. The amnesia for the period during which the crime was committed lends support to his optimistic views concerning the outcome of the case, and his mind becomes, in consequence, wholly taken up with the idea of being acquitted of the murder charge. He remembers nothing of the deed, and therefore must have been absolutely unaware of what he was doing at the time. His hopes are shattered when he is found guilty and sentenced to life imprisonment. His

nervous system is unable to withstand this blow and it yields a second time, only in a more pronounced manner.

One need not enter into a lengthy discussion in order to show that we have here a mental disorder, the origin of which can be definitely traced to psychic causes, the emotional shock accompanying the crime and conviction. Cause and effect are clearly in evidence here. We have before us a well-defined psychogenetic psychosis. In addition to this the course of this man's mental disturbance was influenced to such an extent by his immediate environment that one could practically shape the symptomatology thereof at will. Once, after a prolonged period of a state which might be considered almost normal to the individual, he induced the attending physician to bring his case for consideration before the staff conference with a view to being returned to prison. At this conference it was decided that in view of the very deleterious influence which prison life has had in the past upon this patient it would not be advisable at this date to send him to the penitentiary. Upon being told that he would have to remain at the hospital, patient again became morose, hypochondriacal, refused nourishment, and commenced to hold himself aloof from the other patients. His suspiciousness and vague persecutory ideas with reference to the personnel of the hospital became more pronounced, and he could see no other reason for being kept here than that the officials are continuing in their persecutions of him. I am convinced, without a doubt, that should this man be pardoned, all the manifestation which he now possesses, and which may be considered as pathologic in character, would at once disappear. The difference in the symptomatology of the two attacks

serves to illustrate how difficult it is to positively state what relation these disorders have to hysteria. Here we have an individual whose past life fails to indicate anything which may be taken as of an hysterical character. He develops a psychogenetic disorder in consequence of his crime, the symptomatology of which shows little, if anything, of an hysterical nature. In due course of time he gets well, and after having thrust upon him a life sentence, again returns to us with a mental disorder, the chief feature of which is a functional hemiplegia. There is very little doubt that by studying a cross-section of his second attack we could easily place it under the group of hysteria. Considering, however, the history of the case *in toto*, we would have to proceed rather cautiously in judging of the hysterical element thereof.

Case III. — G. W. W., white, male, aged 26 years, whose hereditary history cannot be definitely determined. It appears that mother was a janitress in Boston, and had several children by various fathers. Patient grew up in an orphanage, and worked on farm until age of 18, when he drifted to Denver, Colorado, and enlisted in the U. S. Navy. He served one enlistment with a good record, was a good sailor, and got along well in every respect. He reënlisted the second time about the middle of 1909, when at the instigation of a fellow sailor he deserted from the Navy in company with the latter. On August 20, 1910, they held up the captain of a ship with the intention of obtaining some money which was stored on board the vessel. In the encounter the captain was killed by the patient's companion, who made his escape, while the patient was apprehended and held on a charge of murder. On August 24th, he was placed in jail at Oakland, California. From the beginning he was

regarded by the jail officials as rather silly and defective. He did not appear to be very much interested in his case, and never spoke of his own initiative to his attorney about it. On May 8, 1911, he was seen for the first time by a psychiatrist. He was then found to be very distractible and inattentive, seemed suspicious and excited and assumed stiff attitudes. He was well oriented, and recognized that he was on trial for murder. It might be mentioned here that although the jail officials apparently noted from the first that the patient was not right, the legal proceedings were continued, and it was only on the 4th or 5th day of his trial that his conduct became such as to strongly suggest that he was insane. A psychiatrist was then called in and he pronounced the patient insane, whereupon the proceedings were stopped at this juncture. Examination at that time revealed the following:—General sensation markedly reduced; hypalgesia, he allowed needles to be stuck into his tongue without flinching; walked in a stiff and stooping fashion; no Romberg; moderate vaso-motor stasis, with bluish, cold hands. Gait uncharacteristic. Eyes reacted to light, directly and consensually, and to accommodation. Patellar, Achilles and arm reflexes markedly exaggerated and equal. No foot clonus, no Babinsky; abdominal reflexes present, cremasteric not elicited; catalepsy not always present.

Mental Examination:—Attitude was variable, but was distinctly that of one in a stupor. Arms, hands and legs, placed in uncomfortable positions, would remain fixed indefinitely, *i.e.*, so observed from 20 to 30 minutes. Did not resent liberties taken with him; smiled in a silly fashion at each person. Orientation perfect; no insight; hallucinations and delusions could not be elicited. Attention could only be gained with great difficulty, and held for a very short time. Retardation was present; movements were slow and stiff. When stimulated, however, he responded promptly

and had no retardation. Speech and writing showed nothing characteristic.

May 11: — Flexibilitas cerea more marked; mutism; retention of saliva; eats food voluntarily; bowels require frequent attention.

May 20: — Requires spoon-feeding; sleeps well; remains always in bed in stiff attitudes.

June 1: — For three or four days refused food, except for one or two meals daily. At times suddenly surprises attendants by sensible remarks, as: Another patient said, "That is G. W. W.," and patient promptly replied, "No, it is Rip Van Winkle." Negativistic signs more marked. Knows physician when eyes are pushed open. At times tries to whistle.

June 13: — For past week has been noisy and excited. When he hears dishes rattle, yells "Chow-chow" for a long time. Continued hot bath for one hour always relieves this excitement. Physical signs negative; Wassermann negative; blood and urinary analysis negative.

June 18: — Admitted to the Government Hospital for the Insane. The Marshal who accompanied the patient from California to this institution states that the patient was resistive and negativistic; that he assumed various constrained attitudes; was untidy, mute, and refused food. All these tendencies were markedly influenced, however, by positive requests of the Marshal. When told that he would be chastised if he did not give up his untidy habits, these disappeared, etc. On admission to the Government Hospital for the Insane the patient had to be carried into the ward, as he refused to walk. He was mute, negativistic, and assumed various uncomfortable and constrained attitudes. Every now and then he would snap at those who handled him, and this would be accompanied by a growl. He was very resistive to the taking of a bath, and suddenly snapped

at the attendants who cared for him. When reprimanded, however, by the Supervisor, and told that he would have to take the bath, he quietly underwent the procedure.

Physical Examination: — Pupils widely dilated. Face somewhat distorted. Pupillary reflexes normal; although limbs would remain in a fixed attitude when so placed, he did not evidence the typical flexibilitas cerea. It seems as though he anticipated the passive movements, and there was present a certain amount of voluntary intent. All superficial reflexes active; winced when pricked with a pin but there was a decided hypalgesia present. He refused food; was mute, and apparently oblivious of everything about him. This, however, was only apparently so, as he showed by various acts that he was more or less aware of his surroundings. For instance, during the examination he suddenly snapped at the examiner, and upon the latter's discomfiture he emitted a momentary giggle. When feeding-tube was placed in his nose, preparatory to feeding, he jumped up and said, "I'll drink it," and drank the entire contents of the pitcher. While some parts of his body remained absolutely fixed, restrained and immovable, his face was constantly undergoing various grimacing motions, accompanied now and then by the snapping of his jaws and a growl. During the following several nights he was very noisy, excitable, singing and shouting throughout the night. Mental content could not be determined at this date.

June 28, 1911: — He remains in same apparent stuporous and catatonic attitude. For past few days has exhibited various childish and silly acts of a meaningless and monotonous nature. Still mute except for an occasional growl. Became very untidy today, but when reprimanded and told he must use the toilet he did so.

July 1, 1911: — Patient has been very noisy on several occasions in the past few days, but always becomes quiet

when requested to do so. Continues negativistic, stuporous and attitudinizing. Today he was overheard saying: "I am a monkey; want to go out in the yard and sit on the benches; there was no plea of insanity; who are those boys? Come in, boys; water, won't drink it because there is poison in it, it looks good, so try it. Don't believe there is anything in it." He persevered in repeating these phrases.

July 2: — Sang all morning in an undertone. Would stop singing and recommence his facial grimaces when anyone entered his room.

July 3: — For the first time since admission patient answered examiner to questions.

Q. "What is your name?"
A. "George Washington."
Q. "How old are you."
A. "36."
Q. "When born?"
A. "1884."
Q. "Occupation?"
A. "Farmer."
Q. "Where born?"
A. "Around Boston."
Q. "What day is this?"
A. "Someone says Tuesday."
Q. "What date?"
A. "June 17, 1911."
Q. "How long have you been here?"
A. "I cannot tell you."
Q. "What is the name of this place?"
A. "U. S. Hospital."
Q. "Who brought you here?"
A. "Can't tell you, he looks like a monkey."
Q. "How long did it take you to get here?"

A. "One night and twenty-four hours."

Q. "When did you come here?"

A. "I cannot tell you when I did come here."

Q. "Don't you really know the name of this place?"

A. "Well, sailors in the Navy call it the 'Red House.'"

Q. "Where is it located?"

A. "Washington, D.C."

Q. "What sort of a place is it?"

A. "Why, it's as good as any place else."

Q. "Who are these people about you?"

A. "They might be soldiers; what are they out there for?"

Q. "Is there anything wrong with them?"

A. "How should I know?"

Q. "Are any of them insane?"

A. "Darn'd if I know."

Q. "How do you feel?"

A. "How did I get cured of my headache? I'll stick a pitchfork through you, and if a pitchfork goes through you, it will go through me too."

Q. "Are you sick?"

A. "I was sick; had a pain in the head."

Q. "How do you feel now?"

A. "Oh, pretty good."

Q. "Is there anything wrong with your mind?"

A. "I don't know, I can't tell you."

Q. "Do you hear any strange noises or voices?"

A. "Can you go over to that tree? Sounds like a baby squealing; it's the man that choked the baby."

Q. "Do you ever see strange things?"

A. "Did I ever see strange things? I might read about them in the magazine."

Q. "Do you ever hear voices?"

A. "I hear voices say to you; 'You are not guilty.'"

Q. "How much money are you worth?"

A. "$100; I'll give it you for my life."

As will be seen from the foregoing stenogram, the patient is only partially oriented, perhaps more so than he shows, because of his tendency to answer questions in a sort of careless manner. There is a slight suggestion of "by speaking" (Vorbeireden). The stenogram also suggests the possibility of the existence of fallacious sense perceptions. Of the utmost importance, however, for our consideration, is the fact that the occurrence which brought about the mental breakdown plays an important rôle in the consciousness of the patient. Amid what may be considered an almost total oblivion to his immediate environment, he hears the voices tell the examiner that he is not guilty, he would give the $100 which he possesses for his life. These are unmistakable signs of the psychogenetic nature of the disorder.

July 31: — Patient is well oriented, talks in a retarded manner; questions are answered for the most part correctly; occasionally, only nearly correct. His memory is good for remote events, but very much clouded for events which have transpired since the commission of the crime. Partial insight is present. He realizes that there must have been something wrong with him. Emotionally not deteriorated. Refuses to discuss his crime, saying it makes him feel bad; talks in a childish, affected tone of voice, and undergoes various grimacing movements; gives frequent evidence of being fully aware of occurrences in his environment; talks and eats voluntarily and is tidy in habits. Occasionally laughs in a silly, affected manner. Flexibilitas cerea and catalepsy entirely disappeared; gained considerably in weight; continues to show marked tendency to be influenced by occurrences in his environment. In general, shows a decided improvement in his condition.

We are dealing here with an individual whose past career is uneventful, as far as is known. He is charged with murder, and upon being tried for this develops a mental disorder. The symptomatology of his psychosis could easily be mistaken for that of catatonic præcox, and, as a matter of fact, had been so diagnosed by the first observer. In studying the case more thoroughly, however, it becomes unmistakably evident that we are not dealing here with a case of catatonia. In the first place, the immediate relation between the emotional shock of the crime of murder and the probable punishment for it, and the development of the mental disorder must be taken into consideration. This is not a mere accidental relationship. But even if we grant that this point cannot be definitely decided, the psychogenetic character of this case cannot be doubted when we remember how the entire symptomatology is absolutely dependent upon and influenced by occurrences in the patient's environment. He refuses to eat, a symptom very common in catatonia, but it is indeed a rare occurrence for a catatonic in the midst of a negativistic stupor and mutism to say, "I'll drink it," and actually drink voluntarily the entire contents of the pitcher in order to avoid tube-feeding. He is untidy in his habits, another common catatonic characteristic, but is it to be expected that a catatonic, in the height of his disorder, will abstain from his filthy habits when threatened to be punished for these? Many more instances of similar nature could be cited in this case.

Another feature which removes all doubt of the psychogenetic nature of this disorder is the important part which the mental experience which was active in the production of the disorder played in the fashioning

of its symptomatology. I alluded before to the patient's answer to the question of whether he heard voices.

The disorder itself, as far as the symptomatology is concerned, is not absolutely typical of any one of the acute psychogenetic states. It partakes of Kutner's "catatonic states in degenerates" as well as Raecke's confusional hallucinatory disturbances in these individuals. That the patient can be classed as one having a degenerative soil is not at all certain in this case.

I have considered briefly the importance of a proper recognition of these cases from the view-point of rendering a proper prognosis. There is another important question which must be discussed in connection with these cases and that is the question of malingering. Picture to yourself an individual, who, to all appearances, has led a normal existence, and never showed anything mentally which might be considered pathologic. He commits a crime, and upon being arrested or upon being placed on trial for his offense, suddenly lapses into a condition of apparently complete dementia. The man, who formerly showed nothing in his conduct and behavior indicative of a mental disorder, suddenly changes into a state where he does not know his name, age, or his whereabout. His answers to questions are irrelevant and of a remarkedly silly coloring. He begins to act in a childish, affected manner, executing many silly, meaningless acts, or he may break out in a wild furious excitement, loudly proclaiming his innocence, and threatening those who arrested him. In addition to this, it is noted that this apparently pathologic condition can be definitely influenced by using strict and positive measures. The untidy habits of the patient may be corrected by urging or threats. The man who

has been mute and refuses to eat can be made to talk and eat voluntarily by threatening him with tube-feeding. Furthermore, in the midst of this apparently total dementia, total blocking of all thought processes, the patient frequently surprises those about him by very sensible remarks of a very clever and pertinent nature, indicating that although apparently oblivious of his environment, he knows what is going on about him.

A picture like this may readily arouse the suspicion that we are dealing with a malingerer, and, indeed, some very prominent German psychiatrists have reported as malingerers cases similar to this. The trained psychiatrist, if unfamiliar with this class of cases, will find himself at a loss to know under what known group of mental disorders to place this condition, as it will at once become apparent to him that it does not fit into any of the well-known psychoses.

In defense of the genuineness of the psychotic manifestations of these patients, I would recall again the transitory mental disturbances of students undergoing examinations. The genuine loss of all knowledge of well-known facts which the old-time strict and severe schoolmasters frequently provoked in school children, differs very little from the pseudo-dementia with which we are dealing here. It concerns a similar total blocking and inhibition of all thought processes, and, like all psychogenetic disorders, has a tendency to disappear upon the removal of the causative factor.

Still, nobody would think for one moment that the child malingers when it is unable to answer questions, though these might concern well-known facts. The consequences of failure to recognize this acute prison-psychotic-complex as a genuine mental disorder may

prove to be very disastrous when we remember to what extent the symptomatology of these psychoses is dependent upon environmental conditions.

The Degenerative Psychoses

I have considered thus far those psychogenetic mental disorders, the etiologic factor of which consisted of a single, more or less isolated emotional occurrence. We have seen that the majority of these patients showed very little, if anything, in their past life which was in any way incompatible with leading a more or less successful existence in the community in which they lived. These patients, we might say, would never have been brought to the attention of the psychiatrist had it not been for the occurrence in their life of an experience which provoked a mental breakdown.

I will now consider a group of cases, in whom the degenerative soil is so prominent that they have been properly called "Psychoses of Degeneracy." They should, however, be considered here, because the various psychotic manifestations of these individuals are purely psychogenetic in nature, and evoked by a certain milieu in which the individual was placed. As my material is derived from the criminal department of the Government Hospital for the Insane, the causative factor in these cases will again be found to be imprisonment. These cases differ from the so-called acute prison-psychotic-complex in that the etiologic factor does not consist in a single emotional experience. We are not dealing here with patients in whom the commission of a crime is an accidental occurrence in their life, that is, still uncorrupted individuals upon

whom the criminal act in itself might act in a deleterious manner. The patients belonging to this group are, as a rule, old offenders, who have long been hardened to crime, and whose entire life is an uninterrupted chain of conflicts with the law. To this group also belong those high-strung individuals with early anti-social tendencies, who from childhood show a marked degree of egotism and self-love; who are very vindictive and revengeful in their reaction to frictions in social life. Upon falling into the hands of the law, they are incapable of adjustment to the new situation, react in an insane and wild manner to the prison routine, and, in consequence, frequently commit grave offenses during imprisonment.

We owe our present knowledge of the psychopathology of these individuals to the excellent work of the followers of the great Magnan, who contributed so richly to the study of degeneracy.

Siefert [9] was the first to clearly differentiate the purely endogenetic disorders from those dependent upon a degenerative soil, and evoked exclusively by outside influences. He divided the eighty-seven cases of psychoses in criminals studied by him into two distinct groups, namely, the real psychoses and the degenerative psychoses. Under the former thirty-three cases he places the well-known forms of dementia præcox, epilepsy, paresis, etc. These, according to him, are not in the least influenced by the milieu in which they occur (in this instance, prison environment). His fifty-four cases of degenerative psychoses, on the other hand, were characterized above all by the fact that they stood in the most intimate relation with the environment in which they occurred, and were wholly influenced by the same. The pathologic, degenerative soil which permitted of

the development of the psychosis in these individuals consisted of irritability, lability, autochthonous fluctuations of mood, fantastic day-dreaming, a heightened subjectivity to the environment, inability to form correct critical judgment concerning unpleasant occurrences about them and a strong tendency to suggestibility. On the physical side these patients were subject to headaches, migraine, restlessness and anxiety, often associated with disturbances of heart-action, hypochondriacal complaints, and a tendency to become easily tired upon physical or psychic exertion. They also showed, as a rule, intolerance for alcohol, and were wont to react to alcoholism in a strongly pathologic manner.

Siefert divides his fifty-four cases of degenerative prison psychoses into the following groups: —

First: — Hysterical degenerative state. These consist of undoubted cases of grave hysteria, with convulsions, physical stigmata, endogenous states of ill-temper, confusional states, Ganser twilight syndromes, etc.

Second: — Simple degenerative states. These differ from the preceding group in that hysterical stigmata are wanting. These patients are subject to severe maniacal outbreaks, motor excitements, mutism, attacks of anxious, delirious states, with confusion, etc.

Third: — Fantastic degenerative forms. This group concerns markedly degenerated individuals with a pathologically exaggerated imaginative faculty, a strong auto-suggestibility, a tendency to deceit and lying, to inherent fluctuations of mood and hysterical stigmata. On this basis there develop conditions of pseudologia-fantastica, systematized delusional formations of all sorts, delirious psychoses, etc.

Fourth: — Paranoid degenerative forms. This group he again subdivides into the querulent and hallucinatory paranoid forms. The former may resemble the typical "Querulantenwahn", a psychosis artificially built up out of extraneous circumstances, and one which rarely develops in freedom, but is of very frequent occurrence in prison. The hallucinatory paranoid form consists of fallacious sense perceptions and delusions of a persecutory nature, often substantiated by a strongly hypochondriacal element; in short, a picture which simulates very closely the real paranoid state.

Fifth: — Prison psychotic states with simulated symptoms.

Sixth: — Dementia-like processes. The individuals belonging to this group are habitual criminals in whom the criminal tendencies become evident at a very early period in life, and who, without giving distinct evidence in their past history of a mental disturbance, develop after prolonged confinement a progressive change of character which eventually leads to frequent rebellious outbreaks against the prison management. They become absolutely unmanageable, neglect their work and duties, and finally have to be transferred to an insane asylum. Here they show nothing characteristic of the well-known dementing processes, as hebephrenia, for example; but very frequently, although quite young, their entire manner and behavior suggest a certain dilapidation and deterioration.

Siefert considers the above-mentioned disease processes as entirely dependent upon and provoked by prison life, in individuals with a tendency to mental deterioration. He comes to the conclusion that the prison psychoses are reactions of pathologic nervous organizations to definite deleterious conditions of life.

They are nothing more than irradiations, distortions, and new creations, on the same degenerative soil which also conditioned the crime.

The importance of Siefert's momentous work cannot be doubted, but whether he was justified in his many subdivisions of the degenerative states is questionable. His own description of the various forms immediately suggests the difficulty of clearly differentiating one from the other.

Bonhoeffer,[10] in a monograph devoted to the subject, endeavors to establish the existence, on the basis of degeneracy, of acute psychotic processes which do not belong to either the manic-depressive, hysterical, or epileptic temperaments, which cannot be placed under any of the known forms of dementia præcox, and which develop as wholly independent psychotic manifestations in particularly predisposed individuals. The material which served for his thesis was gathered from the Berlin Observation Ward for Criminals, among the inmates of which institution he found a great number of degenerative psychoses. In a recent work on the subject of psychogenesis he upholds his former views, and believes he has been able to separate his cases into three distinct groups. The first group comprises certain unstable individuals who show a tendency to the development of simple paranoid psychoses. It concerns patients of a very labile make-up with increased affective reactions, with marked tendencies to impulsions and anti-social acts. These cases are characterized by the fact that they do not concern psychogenetic psychotic exaggerations of a certain temperamental predisposition, but psychically evoked disease states which appear to be irreconcilably opposed to the original personality.

He calls attention to the epileptic seizures of these individuals, which have been so ably described by Bratz.[11] In contradistinction to the genuine endogenetic epilepsy, these patients manifest epileptic seizures as reactions to situations purely psychic in nature. In them, without ever resulting in epileptic dementia, there occur along with the epileptic seizures attacks of unconsciousness, of excitement, dream states, and porio-maniacal outbreaks. They differ from the genuine epilepsy by the absence of the characteristic dementia, of attacks of *petit-mal*, and by the fact that the seizures are never purely endogenous in origin. They are always due to extraneous causes, eminently such of a psychic nature. He believes that more frequently even than actual epileptic seizures are the dream states, excitements, and maniacal outbreaks brought about in these individuals by emotional experiences, and as a result of certain ideas and concepts. He places in this group the proverbial "wild man", the man who goes into a frenzy upon seeing a policeman, etc. Although alcohol may in these individuals prepare the way, the immediate causative factor, however, is the emotional experience, or the recollection of such an experience.

These psychogenetic excitements of degenerates often simulate symptomatologically genuine epilepsy so far as the ferocity of the excitement and the state of consciousness are concerned. In some cases the retention of suggestibility during the attacks shows clearly the psychogenetic character of the disorder, while in others the tendency toward the theatrical and exaggeration is so marked that we are forced to think of an hysterical component. Certain slight symptomatologic features of these psychogenetic states of excitement in degener-

ates appear to furnish a differentiating point between them and the true epileptic condition. Bonhoeffer refers to the strong tendency to disgust-evoking manifestations, to copro-practice which manifest themselves in the soiling of the walls and face with excrements, the drinking of urine, etc. Another characteristic is the frequent total misunderstanding of the situation by these individuals in that they consider themselves to be threatened with impending grave physical danger. In consequence of this they manifest a certain over-aggressiveness, which goes far beyond mere protective reactions, and manifests itself in a senseless breaking and demolishing of furniture. These individuals can be easily distinguished by their superficial intellectual endowment, by a tendency to change of occupation, and early criminality. During imprisonment and under the influence of the stress incident thereto, they develop an acute paranoid symptom-complex, a delirium of reference, accompanied by ideas of prejudice, isolated elementary hallucinations, and irresistible desire to a depressive recapitulation of their past, and a nervous, irritable temper. Consciousness is not clouded, and they remain perfectly oriented in all spheres. The duration of the disorder may vary from a few months to two years, with occasional intermissions. The delusional formation continues only for a short period, and in no instance leads to a retrospective change of the content of consciousness. Very frequently the process subsides upon the removal of the patient into a new environment without leaving any change in the personality of the individual. Insight is not always perfect. The delirium of reference and prejudicial ideas concerning the prison personnel may remain uncorrected.

The cases belonging to his second group are those well-known pestilent individuals who from childhood show an abnormally affective reaction to frictions in social life, in so far as their highly exaggerated, egocentric self-consciousness permits them to endow every unpleasant experience with a personal note of prejudice. They are the poor martyrs, who somehow never seem to get what is coming to them in this world, who are ever ready to assert their rights and leave no stone unturned until they receive what they consider full justice. Such individuals may pass through life, if fortunate enough, without developing a real psychosis. They are then merely burdensome and uncheering elements within their narrow social sphere. Should they, however, meet with an experience, which to them appears as an injustice, they may at once develop typical paranoid pictures, the characteristic feature of which is that the psychic experience which forms the origin of the trouble remains always in the foreground. Bonhoeffer identifies these conditions with Wernicke's psychoses of hyperquantivalent ideas. He very justly says: "The narrower the sphere of activity in which these individuals live, the more frequent the opportunities for conflict are offered by law, discipline, and subordination, the easier it is to develop a psychotic exacerbation of the abnormal temperament even on a lesser pathological basis. This is the reason why officialdom and especially the narrow limits of prison life bring out so forcibly these psychogenetic disorders. In prisoners the psychogenetic character of the disorder becomes especially apparent. One sees how in many cases the transfer from one prison to another, to an observation station, to an insane asylum, puts an end to the process. In certain instances the process seems

to revive itself again when the individual is placed in a similar environment."

Of Bonhoeffer's three subdivisions of degenerative states the preceding one would as a whole appear to me to be especially deserving of a separate classification. Anyone who has had any experience with insane criminals will recall that group of cases in whom the entire psychosis seems to be more or less centered about a certain idea; in most instances, about the idea of not having received a just trial. These individuals, without showing any intellectual impairment, in fact without showing any characteristic which would fit their mental disturbance into any of the known psychoses, constantly evidence a sort of paranoid habitus, a paranoid trend which is exclusively directed against those who had anything to do with their conviction and safe-keeping. The most trivial occurrences in their environment are endowed by them with a personal note of prejudice. The delay of a letter, the refusal to grant some of their unusual requests, an attendant's accidental failure to sweeten their coffee sufficiently, the slightest deviation from the routine greeting of the visiting physician; in short, any such trivial, insignificant occurrence is at once endowed with a special meaning, and explained in a more or less delusional manner. Yet these individuals can reason in a perfectly rational manner on any subject which is not concerned with their conviction or confinement. They are as a rule intellectually bright and keen, and fail to show any evidence of emotional deterioration. On the contrary, their emotions are of such fine and sensitive nature that incidents which an ordinary individual would overlook entirely, offend them to a marked degree, and are reacted to by them

in a very decisive manner. Indeed, one frequently asks himself whether their persecutory ideas deserve to be endowed with the value of actual delusions. I fully agree with Sturrock[12] when he says: "If I refuse to allow a prisoner full scope because he has lifted a knife from the table with which to attack the charge warder, I do not call it a delusion of persecution if he spends the night threatening to murder me because I do not give him justice." One must remember that this is in a measure the normal attitude of the captive towards the captor, and can be seen in a more or less pronounced degree among criminals enjoying a short respite from the law. The essential point here is not the so-called psychosis, but the soil which made the development possible. Not all prisoners, by far, react in this manner to the prison environment. It is only those degenerative individuals who have shown this well-marked paranoic trend all their lifetime, who furnish these cases. As a general rule these conditions are seen in habitual offenders whose entire life has been a round of conflicts with everything they come in contact, and who, outside of prison, figure chiefly in the saloon and gambling house brawls.

That these conditions deserve a more definite classification than the nondescript paranoid state cannot be doubted. These paranoid manifestations are distinct reactions to a definite situation, in this instance, conviction and imprisonment, of individuals whose peculiarly degenerative make-up makes such reactions possible. The question of the particular coloring which these disorders may assume can only take a secondary position to that of the character or make-up with which we are dealing.

Bonhoeffer further speaks of a certain hysterical

element in these cases, but does not believe that on this account these paranoid manifestations should be considered as hysterical. He rather believes that they are more closely allied to the epileptoid temperament. The hysterical component manifests itself in either hysterical stigmata, or, as has often appeared to him, in the fact that the falsifications of memory which these individuals frequently manifest concern themselves solely with the simple overvalued paranoid ideas, and lead to a complete blocking out of unpleasant recollections of the individual's past career. Thus, previous sentences, imprisonments, etc., are totally forgotten. In this, perhaps, we might see the well-known wish factor of hysteria.

The cases which comprise his third group show such a varying symptomatology that it is difficult to form an exact idea of just what characterizes them.

After perusing the work of Bonhoeffer, one feels that the author's endeavors to subdivide his material into this or that group are somewhat artificial. Granted that we are dealing with mental disorders, whose existence can be possible only by a certain degenerative predisposition, the question arises, "Of how much practical value is this constant endeavor at classification and subdivision of the psychotic manifestations which these individuals show?" One must acknowledge that the salient feature here is not the particular coloring which these psychoses assume, but, as we have stated before, the soil upon which they develop. At most, we might say that the symptomatology of these psychoses would depend on the question whether it is the ideational sphere which is mostly concerned, or the affective sphere. Turning to Willmann's excellent contribution to this subject one again meets with

the same endeavors at subdivision and classification. Lack of space will not permit us to enter into an extensive discussion of this author's work. We have already indicated here and there in passing, some of the essential points in the views of this author.

One turns with quite a degree of relief to the momentous work of Birnbaum[13] on the Psychoses of Degeneracy. As far as can be ascertained the author does not endeavor to subdivide his degenerative states into so many types and forms. According to him, the essential characteristics of the degenerative psychoses — namely, the extraordinary determinability and influence which outside impressions have upon the disorder, the mode of genesis and the psychological evolution of the delusions, etc., — may be attributed to the essential ear-marks of the degenerative character; that is, to the exaggerated auto-suggestibility, the great instability of the existing conditions and mental pictures, the disharmony between the perceptive and imaginative capacities and the preponderance of a lively fantastic coloring to the dry thinking of these individuals. They do not form disease processes of a definite characteristic form, but episodic psychotic manifestations on a degenerative soil, and the manifold phases of the collective forms are to be considered as repeated fluctuations about the psychic equilibrium of these individuals. He further noted that the symptomatology of these disorders remained limited to a relatively well systematized delusional fabric, which, however, in contradistinction to paranoia, does not persist for any length of time, but disappears for certain definite reasons. They do not form any typical symptom-complex. The delusional ideas may take on any character; hallucinations may occur in all fields of the

sensorium; consciousness may or may not be clouded, but is usually so in the beginning of the disorder. Recoveries are as a rule gradual, but may set in quite suddenly. Insight may or may not be present. The course of the disorder, like its symptomatology, offers nothing of a definite, characteristic nature.

Thus we see that the distinguishing feature of Birnbaum's degenerative psychoses does not lie in their mode of appearance, in their symptomatology, but in the mechanism of their evolution, and, above all, in their total dependence upon extraneous influences. They are typical psychogenetic disorders, the psychic etiology of which is potent not only in the incitation of the processes, but in the modeling and fashioning of them. Although Birnbaum notices the close relation that exists between these psychoses and the hysterical psychotic manifestations, he would separate them distinctly from hysteria.

Case IV. — A. C., colored female, age 32 on admission to the Government Hospital for the Insane, on June 18, 1909. Father died of dropsy; one brother was killed in a railroad accident; one sister suffered from St. Vitus' dance; another died of tuberculosis. Patient was born in Jamestown, Virginia, was healthy as a child. Does not remember having had the usual diseases of childhood; had a severe attack of typhoid fever when quite young. Attended school until fourteen years of age, having reached the third grade. Upon leaving school she went to work as chambermaid and soon became addicted to the excessive use of alcohol, as a result of which she got into numerous fights and quarrels. In 1895, while intoxicated, she stabbed a man in the back and was sent to Albany Penitentiary for five years and eleven months. During her sojourn there she was sent to

the Matteawan Hospital for Criminal Insane, where she remained forty-five days. Upon being discharged she returned to her home and lived with her mother, assisting her with washing and ironing, following which she led the life of a prostitute for about two years. In 1901 she was sentenced to thirty months imprisonment at Moundsville, Virginia, for theft. Previous to this she had been confined in the Government Hospital for the Insane for about a month with an attack of delirium tremens. After the expiration of her sentence at Moundsville, she returned to Washington and soon after was again arrested for housebreaking and robbery and sentenced on two counts to twenty years imprisonment at Moundsville. While there she had more or less trouble all the time; had numerous fights with other colored women, in several of which she sustained injuries. On February 12, 1907, while working in the sewing room, she became implicated in a quarrel with another inmate, whom she stabbed in the left side of the neck with a pair of scissors. In describing the incident she says: "I pushed them in as far as they would go, twisted them around, opened them and then pulled them out." The woman lived about five minutes after this. The quarrel presumably originated because her antagonist called her some name and accused her of having to serve a "young life sentence." She then told this woman to go back to Anacostia and get the baby she threw over the Anacostia Bridge, at which the latter became quite angry and attacked her with a pair of scissors which culminated in the murder. A. C. was placed in a cell after this and the next day transferred to a dungeon, where she remained until her transfer to this Hospital. While in the dungeon she suffered a great deal with headaches and nervousness; she was absolutely isolated, no one came to her cell, ate her meals through the bars. In this condition she remained about three months. She says she prayed a

good deal during this period, because she was told that she might have to stand trial for murder, in which event they would surely hang her. She was admitted to this institution the first time on May 8, 1907, on a medical certificate which stated that one sister died of pulmonary tuberculosis, and that another is now afflicted with chorea. The patient was addicted to the excessive use of alcohol and cocaine and is considered to be a sexual pervert. Ever since she was admitted to the penitentiary she has exhibited signs and symptoms of insanity; her present symptoms are described as ungovernable temper, attacks of extreme nervousness, attacks of fits resembling those of acute mania, with loss of judgment and complete disregard for the consequences of any of her acts. Delusions of persecution were also noted. Her mother stated that the patient throughout her lifetime would frequently have outbursts of temper, and her brother would tie her down during these attacks to prevent her from injuring members of the family. Physical examination on the first admission was negative. Mentally she complained of being nervous and easily awakened at night; consciousness was clear; she was well oriented; no hallucinations or delusions could be elicited. Intellectually she appeared to be above the average negro in intelligence; she read and wrote, spelled correctly and used good English. Her memory was good for both past and recent events. Throughout her entire sojourn here she was oriented to time, place and person; except for having stated at one time in a sort of careless and apparently indifferent way that she had heard someone calling her by name, and upon looking for the person could find no one, she manifested no hallucinatory disturbances. No delusional ideas were elaborated at any time. Her conduct here was characterized throughout by marked irritability; she frequently threatened to get even with the ward physician, saying she did not propose to fight

open-handed any more and would not enter into a fight without a weapon. She frequently broke window lights without any apparent reason; often was very surly in manner; then again was pleasant and agreeable and assisted with the work on the ward. She assaulted several of the nurses when an attempt was made to restrain her, in order to prevent her breaking window lights. When spoken to about these outbursts of temper she would deny all knowledge of them, saying that she never threatened nor assaulted anyone. She was discharged as recovered on January 12, 1909, and returned to Moundsville Penitentiary. She was again admitted to the Government Hospital for the Insane on June 18, 1909, on a medical certificate which stated that she was very irritable and had a mania for breaking windows; that she was suffering from delusions. No further evidence of insanity was given. On admission she was sullen and disagreeable, had a frown on her face, sat on a chair looking out of the window and was exacting in her demands. She requested to be removed to another ward, where she thought it would be livelier; asked for various medicines, etc. When told that her requests could not be granted, she became very cross and abusive, making threats of things she would do. In the afternoon scratched her arm with a pin and quite a flow f blood was produced, which necessitated restraint. At this she became very excited and endeavored to break the wristlets and get out of the room, proclaiming loudly that if she was going to have wristlets on she would rather be back at Moundsville. She was not very communicative concerning her return to the Hospital; told one of the nurses that she had "carried on high" to get back, and that Moundsville was "a hell of a place." The following day she begged continuously for hypodermics, complained of headache and tried to produce emesis by putting her finger down the œsophagus. When questioned, she answered promptly and intelligently, but

in a sullen manner; stated that on her return to the penitentiary she was placed in a cell formerly occupied by the woman whom she had killed, and that this made her nervous, and frightened her. She would not sleep on the bed provided but used for sleeping purposes a box intended for a table. She said she cried and prayed a great deal until finally, after three weeks, was transferred to another ward. She said that she behaved well and caused no trouble after having been removed from the first cell and does not know why they transferred her over here. Her entire sojourn here on this occasion was characterized by irritability, impulsiveness and destructiveness to property. She was fault-finding to a great extent and threatened the life of some of those about her. She was surly, selfish, and showed a marked tendency to lying. She was shrewd in her endeavors to get herself into the good graces of those in charge of her and on one occasion stated that she was pregnant in order to receive more considerate treatment. This, like many other of her assertions, was false. She was oriented throughout; memory good; no hallucinations or delusions could be elicited; she was very unstable emotionally; reasoning and judgment were defective. Her entire symptomatology was controlled and fashioned almost wholly by her immediate environment. When refused a privilege she would become surly, abusive and threatening to those about her, would destroy everything she could lay hands on, and attack the nurses when the opportunity was favorable. The granting of a privilege again would serve to keep her in a rather tranquil mood. She remained this time until June 21, 1910, when she was again returned to the penitentiary at Moundsville. From information obtained from some officials of that penitentiary, it appears that she is continuing to have her old-time outbursts of temper, during which she becomes absolutely unmanageable, and the only

way to deal with her seems to be to isolate her and leave her absolutely alone until she is over her disturbed state. Between these attacks she behaves quite well, but such behavior has to be encouraged by the granting of various privileges.

CASE V. — J. J. M., aged 24 years, white male, is a well-built young man, whose family history is unknown owing to his refusal to give it. He was born at Chester, South Carolina, in 1885. Childhood and school life uneventful as far as is known. He was a bright scholar of ordinary intellectual attainments. His industrial career, which began early in life, was, according to his statements, normal. He admits, however, losing several positions on account of outbreaks of temper during which he had fights with other employees. He had several gonorrhœal infections, the first one at the age of fifteen; was infected with lues at a very early age. He used alcoholics to a certain extent, and admits having been intoxicated on numerous occasions. In 1906 he was struck on the head with a club by a policeman. Later in the same year he received an injury to the head during a street riot. Neither of these injuries was accompanied by any untoward symptoms. In 1907 or 1908 he was struck on the head by an overhead pump while riding on top of a car. Was unconscious for some time afterwards, later got up and walked unassisted to a nearby station, where he took a train to Cincinnati. There he was confined to a hospital for ten days, undergoing treatment for this injury. He left the hospital one day without being properly discharged; had no ill after effects from this injury. In the summer of 1909 he was arrested in Washington, in company with another fellow, for robbery. They were both released on bond. The patient, however, left the jurisdiction, and when the police went to a nearby city to arrest him he met

them with a loaded pistol. After considerable effort he was finally subdued and arrested. His companion received a short term sentence, while the patient was committed to five years in the Leavenworth Penitentiary. At that time he was living on the earnings of a professional prostitute, to whom he claims he had been married for several years. From correspondence between him and this woman it appears that he fully sanctions her mode of life. Soon after his arrival at the prison the physician noted his excitable and irritable disposition, which became progressively aggravated, finally necessitating his transfer to the observation ward, on December 9, 1910, a little over a month after his imprisonment. The records of the observation ward of the Leavenworth Hospital show the following: —

December 12, 1910: — Patient says he is frightened and asks to go to bed; put to bed at 4 P.M.

December 22, 1910: — While nurse Miller was taking the afternoon temperatures of the several patients at the guard's desk, he was suddenly attacked by M., who began to beat Miller about the head and face, drawing blood. It was noted that M. and another prisoner had resolved themselves into a select coterie for the purpose of being loud and boisterous and disobeying the hospital rules generally. Not a day passes that some gross breach of prison discipline is not committed by them.

December 23, 1910: — M. told the nurse: "If my wife don't write pretty soon, I am going to jump off the landing and kill myself." He complained that the attendant and nurses were talking about him, and that he feels sometimes like going over and smashing some of them, adding: "I know I am a damn fool for thinking that they are fixing up against me, but I can't help it. I know I am going crazy; I wish I could kill myself, cut my throat or something." This patient is decidedly worse, easily excited, suspicious,

hypersensitive, imagines persons are plotting against him. When in conversation, gesticulates with both hands, wags his head and looks wildly out of the eyes. A particular instance of his excitable temper is a startled wild look upon being awakened to have his temperature taken in the morning.

December 24, 1910: — Says he is scared of something, doesn't know what, and wants to go to bed. Continues to receive epilepsy tablets.

January 2, 1911: — Complains of pains through the head and acts as if frightened. His eyes have a glassy appearance and pupils are dilated. At times a suicidal mania attacks him, seemingly using all his strength to overcome it.

His further sojourn there was characterized by maniacal outbursts, during which he would attack those about him. He showed an utter disregard for prison rules, absolutely refused to obey orders, and when an attempt was made to enforce these, his condition became noticeably aggravated, and the maniacal attacks more frequent. He frequently spoke of being frightened at something, of the attendants plotting against him, and persecuting him. During one of his depressions he made a superficial cut on his neck with a piece of glass which necessitated the application of physical restraint. One day two physicians who examined him spoke in his presence of the advisability of operating on his head. Following this he constantly spoke of his fear of being cut up by the physicians, whom he designated as a bunch of anarchists, and the elaboration of this fear remained the dominant feature of his mental disorder. He continued, however, to be profane, vicious and unruly in his behavior. His periodic outbursts of rage were as furious as formerly, he tore up his bed-clothing and personal attire during these fits of anger, which continued to be more or less reactive in character. He is noted as having had several attacks of convulsive seizures closely resembling epilepsy.

Patient was admitted to the Government Hospital for the Insane on April 7, 1911. On admission he was very nervous and apprehensive, would jump and become startled when touched or approached by anyone and when spoken to became highly wrought up emotionally. His body fairly shook with excitement, pupils dilated, face became flushed and he could hardly speak on account of the emotional upset. He spoke of having come from a hell, from a dungeon where a bunch of anarchists were persecuting him, and were going to cut him up and operate on him, that he had heard them talk about it. He was imperfectly oriented, somewhat confused, and to all appearances lacked full appreciation of his new environment. He quieted down, however, at the close of the day and slept well during the night. Physically he was slightly emaciated. No neurological disturbances were noted except that he complained of headaches. When an attempt was made the following morning by a physician to examine him, he flew into a rage, became highly emotional, profane and threatening, showed marked apprehensiveness and expressed the fear of being cut up. He reiterated the persecution of him by the officials at the penitentiary, that he did not care what happened to him, whether he went to hell or heaven, etc. He spoke of killing himself before he would submit to an operation. He refused to eat, saying that the food was not fit to eat, and that he would refrain from taking nourishment until he was given better food. A visit from his wife served to appease him. When given a Hospital night-gown to wear he threw it away, saying he could not sleep in coarse clothing, and this had to be finally substituted by a silk one which his wife brought him. For two weeks following this he was allowed the freedom of the courtyard, where he was quiet and well-behaved, except when spoken to by the physician. At times he would turn with lightning suddenness into a maniacal state, and his

paranoid ideas would come to the front, among which his fear of being operated upon was always predominant. At this time he had not completely transferred his paranoid ideas to the officials here. His clouded consciousness cleared up completely. He read the newspapers daily, took an active part in his immediate environment, and except for the periodic outbreaks of rage when talking to the physician, he showed no outward conduct disorder. He was taking nourishment regularly after a special diet was ordered for him. After a sojourn of about a month, the attention of the officials was called to the fact that the patient was planning an escape by overpowering the attendants, in which plot his wife, who was at that time an inmate of a disreputable house, was to assist him by furnishing him a gun. It was thought advisable to take special precautions with the man, and consequently his freedom of the courtyard had to be curtailed, and he was confined to his room. This was immediately followed by a marked exacerbation of his psychotic manifestations. He became very unruly, abusive and threatening. His outbursts of fury assumed the character of an excited epileptic. They differed, however, from this, in being accompanied by clear consciousness, and in not being endogenetic in their occurrence, but distinctive reactive manifestations to definite situations. Every refusal of a request was followed by one of those outbreaks, during which he would be profane, abusive, destructive and violent, threatening to kill the officials who had anything to do with his safe-keeping, and would elaborate an ill-defined general paranoid trend towards them. He was simply persecuted by a bunch of unchristian anarchists who were running this place; that they would see him in hell first before they would make him behave himself; that he is not here to please anybody except himself; that he recognizes no superiority other than Jesus Christ, etc. Conversely, the

granting of a privilege served to bring him to a perfect calm, when he would talk in a rational and coherent manner, and be free from psychotic manifestations. The granting of the privilege of seeing his wife served to get him to submit himself to a thorough examination, which could not be attempted before. The objective examination revealed no intelligence defect. His reasoning and judgment were unimpaired, memory good, and aside from his paranoid ideas, which consisted in his belief that the officials were persecuting him, and that they were trying to operate on his head, no psychotic manifestations could be determined. Hallucinations had not been evidenced at any time and he possessed no insight. Recently he requested the physician to administer him a dose of 606, for which he was very grateful. He also entered of late into an active correspondence with some attorneys in town with a view to having something done for his case. On July 15, 1911, he appeared before the staff conference of the medical officers of the Hospital for the purpose of determining whether his condition was such as to warrant his transfer back to the penitentiary. Although having been tranquil and normal for several weeks prior to this, upon entering the examining room he at once became highly emotional, abusive and threatening, and everyone who saw him at that time was impressed with the great affective lability which the patient possessed. For a day or so following this experience he continued to be very emotional, irritable and boisterous. Later on his privileges were again returned to him and he resumed a tranquil state of mind, which existed until the time of his transfer to the prison on August 10, 1911. He told the supervisor who accompanied him to the depot that he intended to behave himself when he returned to prison, so that he might enjoy the benefit of his good term allowance and thus have his sentence shortened. Upon his return to the penitentiary he

was immediately placed under observation on account of his peculiar behavior.

The records of that institution show the following: —

August 16: — Became very profane during the afternoon and evening, declaring that the prison authorities were holding up his mail from his wife, and was very profane and vindictive in speaking of the officials.

August 17: — Cursing the prisoners of parole room I as they were coming in from exercise, stating that they were a lot of G . d d . . . . d s . . s of b . . . . . s and that they were holding up his mail.

August 18: — Shouting and cursing through his window during the evening. Got out of bed at 2 A.M., and began to swear and fight an imaginary foe, keeping it up for two hours.

August 19: — Continues to use the most profane language he can towards the prisoners or anyone whom he chances to see.

August 20: — Was very excitable and irritable during the day and evening. Attempted to throw his food in the guard's face, cursing the officials for keeping his wife away from him; claims that he can hear her calling him outside of his cell at night.

August 21: — Cursed the guard because he would not allow him to go out of isolation; sang and whistled during the evening.

August 22: — Very profane and vindictive in his accusations towards the prison officials.

August 23: — Denounced the guard as a black-hander, and said that the guard is bribing the prison officials to hold him in isolation, but that he will not give the guard a damned nickel.

August 29: — Actions and language continue along the same line except that they are growing progressively worse;

cursing the officials, prisoners, etc.; claims they are keeping his wife away from him, and that his mail is being held up; is afraid of being murdered, and says that he is being kept here while his wife is starving; constantly uses loud and profane language.

August 30: — Prisoner whistled and sang during the evening, interspersed with very vile language.

August 31: — Became very violent today, cursing officials, claiming that he was being kept away from his wife and child who were starving. Kept shouting, singing and cursing at intervals all day and far into the night.

September 7: — Continues to have periods of violence almost daily; has hallucinations that he is being haunted by some imaginary foe, whom he sees sitting on his bed when he wakes up at night — a red-headed fellow by the name of Smith. Says that he can hear his wife and child crying outside of his cell, and repeatedly requests that he be allowed to go home to them. Says that his wife and children are starving, and that the prison officials are trying to starve him. Complains of pains in his head, and that his eyes hurt him and that he is going blind. He is inclined to be destructive of late, breaking his electric globes, smashing stool, throwing magazines against window and cell bars.

September 14, 1911: — Says he knows that red-haired Smith is trying to steal his wife, and that he is following him all over the country; that he was about to kill him in Jacksonville, Florida, but that he jumped out of a window. His violent attacks are becoming more severe and pronounced, and he requires constant watching to prevent him from doing himself bodily harm. He was also noted to have occasional mild attacks of *petit mal.*

On his way to Washington from the penitentiary at Leavenworth, upon his second transfer to this institution,

the patient had been shackled to another prisoner who was supposed to be suffering from pulmonary tuberculosis. M. kept on begging the guards to be separated from this prisoner, and this request was finally granted. While going through the State of Iowa he jumped out through the window of the moving train. He was handcuffed at the time. After having gone about thirty miles he was recaptured. He had removed handcuffs soon after his escape from the train.

September 27: — On admission the patient limped and complained of great pain in both knees. Knees were swollen, bruised and discolored, and there was marked tenderness on touching. Patient entered the ward quietly, recognized those about him, and answered questions rationally. Said that aside from having been hurt in the knees, his left shoulder pained him a great deal. Upon being placed in bed he was asked by the examiner why he was sent here, to which he replied: "To get killed, I suppose." Further questions failed to elicit any answers, and the interview had to be discontinued.

September 28: — Patient answered the following questions to the attendant on the ward: —

Q. "What is your name (full Christian name and surname)?"

A. "J. J. M."

Q. "How old are you?"

A. "25."

Q. "When were you born?"

A. "1885."

Q. "What is your occupation?"

A. "Railroad man."

Q. "Where were you born?"

A. "Charleston, South Carolina."

Q. "What day is this?"

A. "Don't know."

Q. "What month, date and year is it?"

A. "August, 1911. Don't know date of month."

Q. "What time is it?"

A. "Don't know."

Q. "Where did you come from?"

A. "Leavenworth."

Q. "Who brought you here?"

A. "Bunch of cut-throats, Sons of . . . . . tried to starve me to death all the way down."

Q. "How long were you in coming?"

A. "Don't know."

Q. "When did you come?"

A. "Don't know what time it was."

Q. "What is the name of this place?"

A. "Don't know."

Q. "Where is it?"

A. "On an island, I guess, some damn thing across the river."

Q. "What sort of a place is this?"

A. "Mad-house."

Q. "Who are these people about you?"

A. "Here to murder me."

Q. "Is there anything wrong with them?"

A. "Nothing but black-hands anarchists."

Q. "Who am I?"

A. "J. S." (correct)

Q. "Why do you suppose I am asking you all these questions?"

A. "Don't know."

Q. "Why were you sent here?"

A. "To be dumped off, I guess."

Q. "How do you feel?"

A. "Pretty bad this morning, my head hurts me."

Q. "Are you sad or happy?"
A. "Neither one."
Q. "Are you worried about something?"
A. "Why, sure I am."
Q. "Did anything strange happen to you for which you can't give yourself an account?"
A. "No."
Q. "Do you hear voices talking to you?"
A. "Yes, hear you talking to me now."
Q. "Do you see any strange things?"
A. "No."
Q. "Do you ever have fits or convulsions?"
A. "No."
Q. "Did you ever try to commit suicide?"
A. "No."
Q. "Is there anybody trying to harm you in any way?"
A. "Yes, those black-hands anarchists."
Q. "How much money are you worth?"
A. "Nothing."

The foregoing two cases are representative of a group which unquestionably forms the most difficult part in the problem of caring for the insane criminals. Here we have a couple of individuals whose entire psychotic manifestations, if such they may be considered, consist of a most wild and vicious rebellion against imprisonment. They are individuals who cannot be kept under any prescribed mode of living, and when this is insisted upon, they react to it in an insane manner.

Bonhoeffer justly termed them "wild men", for wild indeed they are when in one of their tantrums. The question arises, "Wherein lies the cause of this rebellion against discipline?" It certainly cannot be wholly

attributed to the environment, for these individuals behave in a similar manner even when removed to the far more lenient regime of a hospital. We must seek an explanation for the behavior of these individuals in the individual himself, in his make-up.

Looking at the life history of the two foregoing patients we find them both to be of the most depraved class of society. The one is a professional prostitute; the other subsisting upon the earnings of a prostitute. Their relation with man has always been characterized by a sort of vicious vindictiveness. Their high-strung emotional make-up brought them into serious conflict with those about them on many occasions before. Being finally taken hold of by the law and made to submit to a certain well-regulated mode of existence, their inherent characteristics assert themselves in a most decisive way and they react to the situation in the manner of a trapped tiger, stopping at no means to gain their point. The one commits a homicide during one of her outbreaks of passion; the other risks his life to obtain his purpose, by jumping out of a moving train with his hands shackled. Their life seems to be one long series of impulsions, fostered and sustained by the extreme lability of their emotions. Intellectually they show no defect. They are keen and alert to every opportunity which presents itself to them and are very shrewd in the execution of their criminal acts. Finding themselves under a regime which exacts from them a certain submission to rules, to regulations, they begin to misinterpret ordinary occurrences in their environment in a sort of delusional manner: They are persecuted by the warden because the latter insists upon making them behave themselves; the keepers are a bunch of anarchists, whose entire occu-

pation seems to be to persecute them and down them. This for no other reason than because they are made to work and to behave themselves. J. J. M. tells me that he will not behave himself, that he is not here to please anyone but himself and recognizes no authority other than that of Christ. The other says she raised so much hell at the prison that they had to send her back to the hospital. The distinguishing feature of their psychotic manifestations is that they are provoked essentially by definite situations. They are not a mere wild, misdirected, meaningless series of insane acts, such as one would expect from a demented person, but distinct reactions to situations. Refuse them a request and they at once become wild, abusive and vicious, smashing up everything that they can lay hands on; conversely, when granted some of their unreasonable requests, it serves at once to appease them for the time being at least. Their conduct, however, is very detrimental to the prison regime, as discipline cannot be maintained with such disturbing elements about. Their interpretations of discipline are considered as delusions of persecution, their outbursts of temper as typical maniacal outbreaks, and consequently they are shipped off to an insane asylum. Now the question arises whether we are doing our duty by society in declaring these individuals as irresponsible for their acts. In other words, should these individuals with marked and incorrectible criminalistic tendencies, be, so to speak, licensed to ignore the law in its entirety by giving them the protection of an insane asylum? Of course, from a broad, humane point of view, we must realize and appreciate that there is something distinctly wrong with these individuals, that their mental endowments are the essential factors

which determine their behavior. On the other hand, we must not forget that these individuals fully realize that once they have been sent to an insane asylum, they are protected from punishment by law for all future time and they are ever ready to utilize this knowledge, as has been my experience with quite a number of recidivists, who somehow never get into an insane asylum until they are in the hands of the law. The scope of this paper will not permit me to enter into an extensive discussion on the treatment of these cases. I will say this, however, — that we are very far from having solved satisfactorily the question of the care of this particular class of insane criminals. As this paper is not primarily a discussion of the degenerative psychoses, I will refrain from reporting further cases. I believe I have shown by the preceding two cases that the mental disturbances of the degenerative individuals are essentially psychogenetic in origin.

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